	Of Fleatill Service IN		ı		т —	1
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	01	COMP	LETED
					C	2
		FCL011021	B. WING			4/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LEICEST	ER HEIGHTS FAMILY	CARE	OOK DRIVE			
		LEICESTI	ER, NC 2874	.8		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	REGULATORT OR E	SCIDENTII TING INI ORNIATION)	TAG	DEFICIENCY)	MAIL	57.11.2
C 000	Initial Comments		C 000			
	Report by Glenn Ho	oppin				
		Section conducted a				
		on January 14, 2016 beginning				
		ling at 5:00PM at the above				
		DHSR records indicate the				
		nsed on November 10, 1986				
		ome for Six Ambulatory				
	Residents (able to evacuate and respond without any physical or verbal assistance during a fire or					
		Based on this information we				
		ome to maintain compliance				
		he 1984 "Rules for Family				
		ium and Desired Standards				
		he applicable portions of the				
		CAC 13G for Family Care				
		978 North Carolina State				
	Building Code - Sed	ction 409.1G - Residential				
	Care Homes.					
		isit, we cited deficiencies that				
		ole plan of correction. They are				
	as follows:					
C 117	Have Current San.	And Fire Safety Approvals	C 117			
	SECTION .0300 - 1					
		302 DESIGN AND				
	CONSTRUCTION	II barra armant a selfettere e				
	` '	Il have current sanitation and				
		fety inspection reports which				
		I in the home and available for				
	review.					
	This Rule is not me	et as evidenced by:				
		staff member revealed that				
		ave a current approved				
		n report at the time of the				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMP	SURVEY PLETED
		ECI 044024	B. WING		04/4	
		FCL011021	<u> </u>		01/1	14/2016
NAME OF I	PROVIDER OR SUPPLIER		LOOK DRIVE	STATE, ZIP CODE		
LEICEST	ER HEIGHTS FAMILY	/ CARE	ER, NC 2874			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
C 117	Continued From pa	ige 1	C 117			
		DHSR Construction section oved sanitation inspection				
C 135	Bathroom-Hand Gr	ips	C 135			
	SECTION .0300 - 7 10A NCAC 13G .03 (e) Hand grips sha commodes, tubs ar residents.	BO9 BATHROOM				
	had no hand grips of technician install ha	aled that the hall bathrooms on the toilets. Have a qualified andgrips on the toilets. Imentation to the DHSR				
C 153	Houskeeping And F	- urnishings-Clean, Repaired	C 153			
	FURNISHINGS (a) Each family ca (1) have walls, cei coverings kept clea (2) have no chroni (3) have furniture	315 HOUSEKEEPING AND				
	and is damaged thr several places it is trip hazard. There several locations. I	et as evidenced by: vealed that the carpet is soiled rough out the facility. In folding up causing a potential are holes in the carpet in Have a qualified technician replace the carpet throughout				

Division of Health Service Regulation

STATE FORM 5HID21 If continuation sheet 2 of 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
						;
		FCL011021	B. WING		01/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LEICEST	ER HEIGHTS FAMILY	CARE	OOK DRIVE. R, NC 2874			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
C 153	Continued From pa	ge 2	C 153			
	documentation whe	e copies of invoices and photo en this work is complete. e or Duct tape is not a suitable				
	bedrooms there is a Clean and deodorize	vealed that in two of the client a very strong unpleasant odor. The the affected rooms and tion to the DHSR Construction work is complete.				
	the mattress in the licensed exterminate facility for bedbugs facility. Provide a common service of the facility.	vealed a dead bed bug under middle client bedroom. Have a tor evaluate and treat the and any other insects in the copy of the exterminators o the DHSR Construction				
	bedroom furniture a Repair or replace a	realed that the dressers and are in a state of disrepair. Il damaged furniture. Provide the DHSR Construction Section complete.				
	behind the range he	vealed that the wallpaper bood is soiled with grease. Chnician clean or replace the				
	of the client bedroo Clean or paint the v	realed that the walls in several ms are stained and soiled. valls. Provide documentation ruction Section when this is				
		vealed that the bathtubs and nd mildewed. Clean all				

Division of Health Service Regulation

documentation to the DHSR Construction Section

STATE FORM 5HID21 If continuation sheet 3 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING: 01			X3) DATE SURVEY COMPLETED	
		FCL011021	B. WING		01/1	2 4/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•		
LEICES1	ER HEIGHTS FAMILY	CARE	LOOK DRIVE ER, NC 2874				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
C 153	Continued From pa	ge 3	C 153				
	when this is comple	ete.					
C 155	Housekeeping-Free	e of Obstructions	C 155				
	FURNISHINGS (a) Each family ca (5) be maintained orderly manner, free hazards;	315 HOUSEKEEPING AND					
	This Rule is not met as evidenced by: 1. Observations revealed that the resident bedrooms are severely cluttered and unkempt. There are boxes and resident clothes and possessions laying on the floor and pose a significant trip hazard. Clean and organize all resident bedrooms. Provide the DHSR Construction section photo documentation when this work is complete.						
	stairs were with clu wheelchairs and oth a trip hazard. Rem the basement stairs	her foreign objects presenting ove all foreign objects from s. Provide the DHSR n with photo documentation					
	middle bedroom. It because there is no bedroom. See item resident bedroom s	vealed an oxygen ng kept in the hall for use in the t is being kept in the hallway o room for it in the resident n 1 of this tag and organize the to that the concentrator can be needroom where it is being					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMP	SURVEY LETED
		FCL011021	B. WING		01/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LEICEST	ER HEIGHTS FAMILY	CARE	OOK DRIVE R, NC 2874			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
C 155	Continued From pa	ge 4	C 155			
		to documentation to the DHSR n when this work is complete.				
	Remove all combus and neatly store ho present a trip hazar	ne DHSR Construction Section				
	running across the bedroom creating a Relocate the phone hazard. Provide the	vealed that a telephone cord is floor in the far right client a potential trip hazard. e cord to eliminate the trip e DHSR Construction Section intation when this is complete.				
	device laying on the creating a trip haza for the device. Rer and store the devic	realed a breathing treatment e floor in the living room rd and a unsanitary condition nove the device from the floor e in accordance with sanitary nanufacturers guidelines.				
	stored in the hallwa the hallway and cor Remove the oxyger hallway. Provide pl	realed an oxygen concentrator by. This dimishes the width of institutes a trip hazard. In concentrator from the hoto documentation to the in Section when this is				
C 162	Bedroom Furnishin	gs-Bed	C 162			
	FURNISHINGS	THE BUILDING 315 HOUSEKEEPING AND				

Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMP	SURVEY LETED
		ECI 044004	B. WING		C 01/14/2016	
		FCL011021	B. WING		01/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LEICEST	ER HEIGHTS FAMILY	CARE	LOOK DRIVE ER, NC 2874			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
C 162	resident: (1) A bed equippe mattress or solid lininerspring or foam appropriately equip needed. A water be resident and permit to have the followin (A) at least one pil (B) clean top and with bed changed a least once a week; (C) clean bedspreas needed; (e) This Rule sha homes. This Rule is not measure as needed; Conservations reversident beds did not interview with a resident beds. Provide clean sheer resident beds. Provi	repair and clean for each d with box springs and ak springs and no-sag a mattress. Hospital bed ped shall be arranged for as ed is allowed if requested by a tted by the home. Each bed is g: llow with clean pillow case; bottom sheets on the bed, as often as necessary but at and ad and other clean coverings Il apply to new and existing et as evidenced by: vealed that three of the ot have sheets on them. An ident revealed that they on the bed in several weeks. ts and pillow cases for all vide the DHSR Construction mentation when this work is e resident beds the led and unkempt. Clean all place any severely worn or	C 162			
C 174	Construction section this item is completed	n with documentation when	C 174			
	SECTION .0300 - T 10A NCAC 13G .03	THE BUILDING 817 BUILDING SERVICE				

Division of Health Service Regulation

DIVISION	of Health Service Re	eguiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	01	COMP	LETED
						ا ،
		FCL011021	B. WING			4/2016
		1 02011021			J 01/1	4/2010
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
. 5.0507	ED LIEIGUES EARIUM	16 OVER	LOOK DRIVE	Ē		
LEICE91	ER HEIGHTS FAMILY	LEICEST	ER, NC 2874	18		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				DEI TOIEITO!)		
C 174	Continued From pa	ige 6	C 174			
	FOLIDMENT					
	EQUIPMENT	ad all fire pefety, electrical				
		nd all fire safety, electrical, umbing equipment in a family				
		maintained in a safe and				
	operating condition.					
		apply to new and existing				
	family care homes.					
	Turning Cure Tromicor					
	This Rule is not me	et as evidenced by:				
		realed that the bathtub in the				
	hall bath is out of se	ervice due to plumbing				
		qualified technician make all				
		and put the bathtub back in				
		ceipts and copies of invoices				
	to the DHSR Const	ruction Section when this work				
	is complete.					
		vealed that an oxygen				
		placed in the hall is plugged				
		om GFCI receptacle. Unplug				
		om the bathroom GFCI				
		g it in to a non GFCI receptacle the manufacturers operating				
		the manufacturers operating the documentation to the DHSR				
		on when this is complete.				
		when the le complete.				
	3. Observations rev	vealed that the dryer duct has				
		ted in the crawl space and the				
		lint into the crawl space.				
		chnician repair the dryer duct.				
		mentation to the DHSR				
		n when this is complete.				
		vealed a large build up of dust				
		space as a result of Item 3				
		Remove the lint and dust that				
		m the dryer. Provide photo				
	documentation whe	en this item is complete.				
	5 01 "					
	Observations rev	realed that the kitchen floor is				

DIVISION	OI FICAILII SCIVICE IXC	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
and Plan	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	01	COMP	LETED
						,
		FCL011021	B. WING			4/2016
		1 02011021			<u> </u>	7,2010
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
I EICEST	ER HEIGHTS FAMILY	CARE 16 OVERL	OOK DRIVE			
LLICLS	LIX IILIGIII 3 I AMILI	LEICESTE	R, NC 2874	18		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
				DEFICIENCY)		
C 174	Continued From pa		C 174			
	qualified technician and repair or replace	es are cracked. Have a obtain all required permits the the kitchen floor. Provide and approvals when the				
	soft around the tub observed that the fle are waterdamaged technician obtain al or replace the bathr	realed that the hall bath floor is and toilet. It was also oor joists under the bathroom and rotted. Have a qualified I required permits and repair from floor. Provide copies of rovals when the repair is				
	soiled and needs to Clean and paint the	realed that the front door is be cleaned and painted. Front door. Provide photo be DHSR Construction Section ete.				
	front porch is unpair Have a qualified tec damaged fascia and surfaces. Provide p	realed that the fascia on the nted and is water damaged. chnician repair or replace any d paint all unpainted exterior photo documentation to the a Section when this is				
	front porch. This is The oxygen tank was survey. Modify the procedures to ensu used or stored in a Provide documenta Section when this was	•				
	10 Observations re	vealed that the soffit is				

Division of Health Service Regulation

damaged near the rear porch by the residents

PCL011021 B. WING D. WING O1/14/2016 STREET ADDRESS, CITY, STATE, ZIP CODE 16 OVERLOOK DRIVE LEICESTER HEIGHTS FAMILY CARE LEICESTER, NC 28748	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 16 OVERLOOK DRIVE			FCL011021		B. WING			
LEICESTER HEIGHTS FAMILY CARE	NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 01,	1-1/2010
	LEICES	TER HEIGHTS FAMILY	CARE					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED B	Y FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
bedrooms. Have a qualified technician repair and paint the damaged soffit. Provide receipts and photo documentation to the DHSR Construction section when this work is complete. 11. Observations revealed an unprotected vent protruding from the ground next to the septic tank by the rear steps. It is a potential trip hazard to residents and staff. Have a qualified technician place a cover or guard over this vent. Provide photo documentation to the DHSR Construction Section. 12. Observations revealed that the sliding glass door near the residents bedrooms has a broken wheel on the bottom of the door making it difficult to open the door. Have a qualified technician repair or replace the door. Provide receipts and photo documentation to the DHSR Construction section when this repair is complete. 13. Observations revealed that the window sill in the far right resident bedroom is not painted and covered with dirt and dead insects. Clean and paint the windowsill. Provide the DHSR Construction section Section with photo documentation when this repair is complete. 14. Observations revealed a light switch missing the dimmer knob in two locations. Have a qualified technician repair or replace the damaged light switches. Provide documentation to the DHSR Construction Section when this work is complete. 15. Observations revealed a white powder in the kitchen drawers. Interview with the staff indicated it was an insecticide used to kill insects. No information was available on the what type of	C 174	bedrooms. Have a paint the damaged photo documentatic section when this was a paint the documentation section when this was an insecticid wheel on the bottor to open the door. It repair or replace the photo documentation section when this resident with the windowsil Construction Section when this repair is was an insecticid was an insecticid was an insecticid was a section was an insecticid was a section was an insecticid was a section when this was an insecticid was an i	qualified technician soffit. Provide recept to the DHSR Convork is complete. Evealed an unprotect ground next to the later a qualified test and over this vent. From to the DHSR Convorted the desired over this vent. From to the DHSR Convorted the door making have a qualified test bedrooms has most the door making have a qualified test bedroom is not part of the DHSR Convorted the DHSR convolved the DHSR convorted the DHSR convorted the DHSR convolved the DHSR convo	inted vent septic tank lazard to echnician Provide enstruction ing glass a broken g it difficult enician eipts and enstruction dow sill in linted and ean and Rependent en this work order in the eff indicated s. No	C 174			

Division of Health Service Regulation

STATE FORM 5899 5HID21 If continuation sheet 9 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED	
		FCL01	11021	B. WING		01	C / 14/2016
NAME OF PROVIDE	R OR SUPPLIER	1 020			STATE, ZIP CODE	01/	14/2010
LEICESTER HEI	GHTS FAMIL	CARE		OOK DRIVE			
	ACH DEFICIENC		EFICIENCIES CEDED BY FULL G INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
around kitched docume about 16. Of uncovering the sire resided install proper docume when 18. In heater element receip Constant 19. Of microvering the element receip constant 19. Of microvering the element receip constant	n drawers an nentation to the insecticion bservations rered electricane hall. Have documentation when this inservations resitting on the lighting on the lighting for the nentation to the far left climits is removed the far left climits and fins. If you replace the sand photomatical fire hazard that this election of this electrical load of the phess of invoices of this electrical for	nsils. Thoro d utensils are DHSR Colle that was userevealed that all junction be a qualified electrical junction to the DHs complete. Evealed that vanity in the samajor she the lamp in the vanity ligher esidents he DHSR Colled. The the defendance of the the documentation when this evealed a minary a client bedinged into the difference of the the two Construction of the the two Constructions of the two Constructions of the the	onstruction Section used. It there is an ox in the ceiling technician oction box. Provide ISR Construction Ithere is a corded bathroom next to book hazard to have a construction section on the baseboard on the baseboard on the baseboard on the baseboard of the construction section of the DHSR of the is completed. In fridge and a room. Both a same circuit.	C 174			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
	FCL011021	B. WING		C 01/14/2016	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LEICESTER HEIGHTS FAMIL	Y CARE	LOOK DRIVE ER, NC 2874			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉ	ETE
DHSR Construction meets a minimum rating. If the panel the paneling with a meets a minimum rating. Provide con	age 10 ide documentation to the n Section that this paneling of a class C flame spread ing has not been treated, treat fire retardent additive that of a class c flame spread bies of the additive labels, and SR Construction Section.	C 174			
 (a) The outside gramily care homes and safe condition. This Rule is not many the same safe conditions. This Rule is not many the same safe conditions. Observations reconditioner. Provide Construction Sections reconstruction Sections. 2. Observations reconstructions of the unused air composed emergency of the unused air composed in the unused in t	THE BUILDING 318 OUTSIDE PREMISES rounds of new and existing shall be maintained in a clean	C 183			

	IT OF DEFICIENCIES		(VO) MULTIPL	E CONSTRUCTION	(V2) DATE	CLIDVEY
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND FLAIN	OF SOURCE HOW	IDENTIFICATION NOWIDER.	A. BUILDING:	01	CONIF	
					C	; l
		FCL011021	B. WING			4/2016
			I		V 17 1	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LEICEST	ER HEIGHTS FAMILY	CARE 16 OVERL	OOK DRIVE			
LLIOLOI	LITTICITIONAL	LEICESTE	ER, NC 2874	8		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				,		
C 123	Outside Entrances/	Fxits	C 123			
0 .20	Outoide Entrarioco/	LAIG	0 .20			
	IV. The Building					
	C. Physical Enviror	nment				
		es/Exits (10 NCAC 42C				
	.2209)	C3/EXICS (10 140/10 420				
	,	ust have at least two exits. If				
		the exits must be as remote				
		reasonably possible.				
		rance/exit door must be a				
		th of three feet and another				
		clear width of two feet and				
		i clear width or two reet and				
	eight inches.	side entrances/exits for the				
		I must be at ground level or				
		with a 1 inch rise for each 12				
		the ramp. If there are only two				
		e entrances/exits must be as				
		other as reasonably possible.				
		or the ramp at exits not at				
		s to homes which have at least				
		eeds personal assistance in				
	getting up or down					
		s must be easily operable, by				
	<u> </u>	on, from the inside at all times				
	without keys.					
		it must be free of all				
	obstructions or imp	ediments to allow for full				
	instant use in case	of fire or other emergency.				
		s, stoops and ramps must be				
	provided with handr					
						
	This Rule is not me					
		ealed that the back porch				
	leading into the staf	ff quarters does not have				
		e porch. Have a qualified				
		andrails on the back porch.				
	Provide copies of in					
		ne DHSR Construction Section				
	when this item is co					
	WITCH THIS REITH IS CO	mpioto.	I			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED							
		FCL011021	B. WING		01/1	; 4/2016						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
LEICESTER HEIGHTS FAMILY CARE 16 OVERLOOK DRIVE LEICESTER, NC 28748												
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE						
C 123	2. Observations revinto the rear of the rails on the left side does not meet the of ramp requirement technician obtain a ramp that meets the above reference non-ambulatory reservative above required, however meet the above required the rear ramp and i meet all building co DHSR Construction	ge 12 realed that the ramp leading facility does not have hand of the ramp. Also the ramp I inch rise to every 12 inches at. Have a qualified required permits and install a requirements of this rule. Per red rule the facility has no idents so the ramp is not if the ramp is present it must uirements, or you can remove install stairs with handrails that de requirements. Provide the in Section with copies of all als pertaining to this repair.										
C 134	.2213) 3. The home must station U.L. listed solocations as determ Services and U.L. liand basement. The wired to the house	uirement (10 NCAC 42C provide automatic, single moke (ionization) detectors in lined by the Division of Facility sted heat detectors in the atticese detectors must be directly current.										
	the attic and crawl s system that is no lo required permits fro and have a qualified heat detectors that device in the reside	et as evidenced by: led that the heat detectors in space are connected to a nger in use. Obtain the local building official d technician install U.L. Listed have a designated sounding nt living area. Provide copies pprovals to the DHSR										

NAME OF PROVIDER OR SUPPLIER LEICESTER HEIGHTS FAMILY CARE STREET ADDRESS, CITY, STATE, ZIP CODE 16 OVERLOOK DRIVE LEICESTER, NC 28748 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED						
NAME OF PROVIDER OR SUPPLIER LEICESTER HEIGHTS FAMILY CARE STREET ADDRESS, CITY, STATE, ZIP CODE 16 OVERLOOK DRIVE LEICESTER, NC 28748 (X4) ID PROVIDER'S PLAN OF CORRECTION (X						(С						
LEICESTER HEIGHTS FAMILY CARE 16 OVERLOOK DRIVE LEICESTER, NC 28748 (X4) ID PROVIDER'S PLAN OF CORRECTION (X			FCL011021	B. WING		01/1	14/2016						
LEICESTER HEIGHTS FAMILY CARE LEICESTER, NC 28748 (X4) ID PROVIDER'S PLAN OF CORRECTION (X													
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMI		(EACH DEFICIENC)	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	(X5) COMPLETE DATE							
C 134 Continued From page 13 Construction section when this is complete. Contact the DHSR Construction section for an inspection of the completed heat detectors when the installation is complete.	C 134	Construction section Contact the DHSR inspection of the co	ion section when this is complete. see DHSR Construction section for an of the completed heat detectors when	C 134									